Subject: **Billing and Payment: General Statements**

Purpose:

- To provide direction to staff members in their interaction with patients and guarantors
- To ensure the protection of the Facility's cash flow and consumer satisfaction
- To avoid potential bad debts by operating under a prudent and effective payment policy
- To provide education to patients and guarantors as it relates to billing and collections of payment for services rendered.
- To inform patient of deductibles, copays, coinsurance amounts & other patient responsibility amounts
- To provide a pathway for consistency in billing and collections
- To establish that payment on accounts will be pursued consistently, regardless of race, age, gender, ethnic background, national origin, citizenship, primary language, religion, education, employment or student status, disposition, relationship, insurance coverage, community standing, or any other discriminatory differentiating factor.
- To establish that IOS will not engage in any extraordinary collection actions (as defined herein) against an individual to obtain payment for care before reasonable efforts have been made to determine whether the individual is eligible for assistance for the care under Healthcare Financial Assistance (HFA) Policy.

Scope:

- Administrative Director (AD)
- Chief Nursing officer (CNO)
- Director of Finance, Business Office, Registration, and IT
- Designated Staff

Definition:

AGB – Amount generally billed for medically necessary care to individuals who have insurance coverage.

Application Period – The period during which IOS must accept and process an application for financial assistance under its HFA policy submitted by an individual in order to have made reasonable efforts to determine whether the individual is eligible for financial assistance under the policy. The Application Period begins on the date the care is provided and ends on the latter of the 240th day after the date that the first post-discharge billing statement for the care is provided or at least 30 days after IOS provides the individual with a written notice that sets a deadline after which ECAs may be initiated.

ECAs – ECAs are Extraordinary Collection Actions taken by IOS against an individual related to obtaining payment of a bill for care covered under IOS's HFA policy that require a legal or judicial process or involve selling an individual's debt to party or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

HFA – IOS's Healthcare Financial Assistance Policy.

HFA-Eligible Individual – An individual eligible for financial assistance under IOS's HFA policy (without regard to whether the individual has applied for assistance under the HFA policy).

Policy:

1. It is the policy of IOS that payment is due when services are rendered.

2. Any patient "self-pay" portion is due within thirty (30) days of receipt of the service. [For purposes of definition: "self-pay" portion is defined as non-covered services, copayments, and deductibles.]

3. Every guarantor will be given reasonable time and communication to be aware of and understand their financial responsibility. The guarantor will be held financially responsible for services actually provided and adequately documented.

4. IOS representatives and/or its designee will widely publicize its HFA policy by providing a copy of

the plain language summary of the policy prior to the patient being discharged.

5. Understanding each guarantor's insurance coverage is the responsibility of the guarantor. Any self-pay liability secondary to insurance coverage is defined by the guarantor's insurance coverage and benefit design. I O S relies on the explanation of benefits and other information from the guarantor and the insurance carrier for eligibility, adjudication of the claim, patient responsibility determinations.

6. A statement of hospital services is sent to the patient/guarantor in incremental billing cycles. In cases when the patient has no insurance coverage, that is a self-pay patient, the statement is sent after services are rendered. In most cases when patients have coverage through an insurance carrier, the statements are sent after the services have been rendered, claim is submitted, and claim has been adjudicated by the insurance carrier. There are some cases, for example, when there is a stop in the adjudication of a claim due to the patient needing to provide additional information, where a statement will be sent to the patient and/or guarantor prior to claim processing.

7. IOS representatives and/or their designees may attempt to contact the patient/guarantor (via telephone, mail, or email) during the statement billing cycle in order to pursue collections. Collection efforts are documented on the patient's account.

Procedure:

1. IOS will submit claims to insurance companies according to established guidelines.

2. Complete billing information must be presented at the time of registration and/or admission.

3. IOS reserves the right, where agreements with the payer are not to the contrary, to determine the length of time before the account becomes the responsibility of the patient and their guarantor due to the lack of timely payment from the insurance company.

4. At no time, unless agreed to with the insurance company to the contrary, will an anticipated insurance payment override the patient's obligation to pay the balance outstanding.

5. Patients and guarantors may request an itemized bill by contacting a representative of the Accounts Receivable Department. IOS does not routinely send an itemized bill to the patient.

6. The guarantor will receive a monthly statement that provides an account status and lists any activity occurring since the last statement.

7. Every effort will be made to assure that every patient account statement is accurate and easily understood by "lay persons".

Statement Cycle:

The statement cycle will be measured from the first statement sent to the patient (date sent) and include the following:

1. Subsequent statements sent to the patient/guarantor in 30 day increments to derive at the statement process:
   a. 1st – Date of first billing
   b. 2nd – 30 Days post
   c. 3rd – 60 Days post
   d. 4th – 90 Days post and notice of submission to Collection Agency if amounts left unpaid or HFA application not received
   e. 5th – 120 Days post - Submission to Collection Agency
   f. A secondary Collection Agency may be used, subject to the provisions of this policy.

Extraordinary Collection Actions (ECAs):

It is the policy of IOS not to engage in ECAs against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is eligible for assistance under its HFA policy.

1. ECAs include:
    a. Selling a patient's debt to another party;
    b. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus;
    c. Actions requiring legal or judicial process, such as commencing a civil action against an individual and placing a lien on an individual's property (although exceptions include filing a proof of claim in bankruptcy and hospital liens on personal injury judgments/settlements) or garnishing of wages.

2. IOS may pursue all available means in the collection of delinquent accounts including those actions requiring a legal or judicial process. IOS must be notified of and approve of any legal action being taken in the collection of delinquent accounts by any vendors working on behalf of IOS.

Efforts to Determine HFA Eligibility:

1. IOS will allow patients to submit complete HFA applications during a 240 day Application Period (as described herein).

2. IOS will not engage in ECAs against the patient or guarantor without making reasonable efforts to determine the patient's eligibility under the HFA policy. Specifically:
    a. IOS will notify individuals about the HFA policy as described herein before initiating any ECAs to obtain payment for the care and refrain from initiating such ECAs for at least 120 days from the first post-discharge billing statement for the care.
    b. If IOS intends to pursue ECAs, the following will occur at least 30 days before first initiating one or more ECAs:
        1) IOS will notify the patient in writing that financial assistance is available for eligible individuals, identifies the ECAs the facility (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECAs may be initiated that is no earlier than 30 days after the date that the written notice is provided;
        2) The above notice will include a plain language summary of the HFA policy;
        3) IOS will make a reasonable effort to orally notify the patient about the HFA policy and how the individual may obtain assistance with the application process.
    c. If IOS aggregates an individual's outstanding bills for multiple episodes of care before initiating one or more ECAs to obtain payment for those bills, it will refrain from initiating the ECAs until 120 days after it provided the first post-discharge billing statement for the most recent episode of care included in the aggregation.

Processing HFA Applications:

1. If an individual submits an incomplete HFA application during the application period, IOS will:
    a. Suspend any ECAs to obtain payment for the care; and
    b. Provide the individual with a written notice that describes the additional information and/or documentation required under the HFA or HFA application form that must be submitted to complete the application and that includes the IOS contact information.
    c. Suspend any ECAs to obtain payment for the care; and
    d. Provide the individual with a written notice that describes the additional information and/or documentation required under the HFA or HFA application form that must be submitted to complete the application and that includes the IOS contact information.
2. If an individual submits a complete HFA application during the application period, IOS will:
    a. Suspend any ECAs to obtain payment for the care;

b. Make an eligibility determination as to whether the individual is HFA-eligible for the care and notify the individual in writing of the eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination.
c. If the individual is determined to be HFA-eligible for the care, IOS will:
    1) Refund to the individual any amount he or she paid for the care (whether to IOS or any other party to whom IOS has referred to sold the individual's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying as an HFA-eligible individual, unless such excess amount is less than $5 (or such other amount published in the Internal Revenue Bulletin).
    2) Take all reasonably available measures to reverse any ECA (with the exception of a sale of debt) taken against the individual to obtain payment for the care.

3. When no HFA application is submitted, unless and until IOS receives a HFA application during the Application Period, IOS may initiate ECAs to obtain payment for the care once it has notified the individual about the HFA policy as described herein.

<u>Miscellaneous Provisions:</u>

1. Anti-Abuse Rule – IOS will not base its determination that an individual is not HFA- eligible on information that IOS has reason to believe is unreliable or incorrect or on information obtained from the individual under duress or through the use of coercive practices.

2. Determining Medicaid Eligibility – IOS will not fail to have made reasonable efforts to determine whether an individual is HFA-eligible for care if, upon receiving a complete HFA application from an individual who IOS believes may qualify for Medicaid, IOS postpones determining whether the individual is HFA-eligible for the care until after the individual's Medicaid application has been completed and submitted and a determined as to the individual's Medicaid eligibility has been made.

3. No Waiver of HFA Application – Obtaining a signed waiver from an individual, such as a signed statement that the individual does not wish to apply for assistance under the HFA policy or receive the notifications described herein, will not itself constitute a determination that the individual is not HFA-eligible.

4. Final Authority for Determining HFA Eligibility – Final authority for determining that IOS has made reasonable efforts to determine whether an individual is HFA-eligible and may therefore engage in ECAs against the individual rests with the IOS Business Office.

5. Agreements with Other Parties – If IOS sells or refers an individual's debt related to care to another party, IOS will enter into a legally binding written agreement with the party that is reasonably designed to ensure that no ECAs are taken to obtain payment for the care until reasonable efforts have been made to determine whether the individual is HFA-eligible for the care.

6. Providing Documents Electronically – IOS may provide any written notice or communication described in this policy electronically (for example, by email) to any individual who indicates he or she prefers to receive the written notice or communication electronically.

Correspondence concerning IOS HFA policies should be sent to the following:

- Institute for Orthopaedic Surgery
- Attn: Billing Department
- 801 Medical Drive
- Lima, Ohio 45804

Questions concerning IOS HFA policies should be directed to: (567) 940-3263

Additional information is available at: www.ioshospital.com/Hospital Billing & Financial Assistance